focusing primarily within the Department of (Internal) Medicine (as a Division or Section of Gerontology and Geriatric Medicine), reaching out in collaboration to all other disciplines within that largest clinical department (with each of the medical subspecialties as well as general internal medicine). However, the supraspecialty definition also dictated that we develop strong, synergistic relationships with multiple other departments in the school of medicine (e.g., psychiatry, neurology, physical medicine and rehabilitation, and surgery and its related specialties and subspecialties) as well as other health sciences schools (critically including nursing, social work, and public health), generally under the umbrella of a center or institute on aging.

The logic of this approach was rooted in the historically based, realistic assumption that geriatricians will remain relatively few in number (indeed, currently less than 1% of United States medical graduates pursue geriatrics at the fellowship level); hence, in the interest of our burgeoning elderly population, the influence of these precious few geriatricians would have to be leveraged maximally through their concentration at academic health centers as researchers, educators, and innovative developers of model programs of both preventive gerontology and geriatric health care. This approach was also designed to foster development of a generation of gerontologists and geriatricians who would mature to become major leaders of academic health centers as center directors, department chairs, and deans in positions affording the opportunity to “gerontologize” the institution in the broadest and most enduring manner.

Perhaps predictably, pursuing this philosophy exerted a profound personal influence upon me and my family. Prepared for a life of academic peregrination and the challenge of geriatric program development by a sabbatical year in the United Kingdom in 1977–1978 to experience the world-renowned British approach to geriatrics, my determination to build geriatrics close to the center of the Department of Medicine led to my progression from Division Head (at the University of Washington), to Vice-Chair (at Johns Hopkins, 1982–1986), and finally to Chair of Internal Medicine (at Wake Forest 1986–1998) before our return in 1999 to our beloved Seattle and the University of Washington and Veterans Affairs Puget Sound Health Care System.

Has this strategy been validated by our experience at these three centers? On balance, yes, I believe. On the positive side that one positive development, especially in recent years, which have witnessed an accelerating rise in numbers of departments of geriatrics. Thus, on this issue, the jury clearly remains out.

And I submit that our identity crisis is likely to persist until the whole of medicine and all of the health care professions fully embrace the responsibility of providing optimal care to the oncoming tsunami of aging baby boomers. When that transformation occurs, however, I optimistically predict that geriatrics will clearly emerge at the center of society’s successful response to this challenge, and that its premium value as an integrating “supraspecialty” strongly tethered to internal medicine and its subspecialties will prevail and endure.

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Reference

Commentary

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John Morley’s “A Brief History of Geriatrics” (1) is brief indeed, but it is packed so tightly with so much useful information—from Biblical times into the 21st century—that it propels the reader through the millennia at speeds entirely appropriate for the space age. And, it is characteristic also of John Morley who has been one of the most productive contributors to the expanding knowledge base in geriatrics and its dissemination, as well as the development of a continuing stream of well-trained geriatricians.

I am delighted to fulfill the request to comment on the history of geriatrics from a different point of view. My point of view is the personal view of a psychiatrist witnessing, and at times participating in, the birth, growth, and maturation of the new field of geriatric psychiatry. My interest in the field of aging spans nearly six decades, and antedated my entering medical school. Thus, I became keenly aware of the lack of interest in aging exhibited by faculty and students alike. And, it was no different when I entered the field of psychiatry, although psychologists had been active in gerontology for years; the American Psychological Association had created a new Division of Adulthood and Old Age, Division 20, now called Division of Adult Development And Aging—back in 1945, just about the same time that The Gerontological Society of America was founded. These two organizations provided intellectual
excitement as well as a supportive network for those of us eager to explore the effects of advancing age on one of the most prized human attributes—our higher mental functions.

At that time, psychiatrists interested in aging had no organization of their own, and the American Geriatrics Society (AGS) welcomed us. I remember well one AGS annual meeting, in the 1960s I believe, when the keynote speaker, one of the country’s most prominent cardiologists, chastised the membership for craving special attention for geriatrics. He insisted that there was nothing special worth knowing about older people that every clinician did not know already. After all, he said, most of our practice is with geriatric patients! Of course, the audience was appalled. But to geriatric psychiatrists, it was a familiar scene. Except for a handful of pioneers (many of them listed in John Morley’s “A Brief History of Geriatrics”), psychiatrists simply ignored patients over age 40 or so.

As John Morley points out, the Department of Veterans Affairs has played an important part in changing attitudes toward aging through the development of geriatrics and geriatric psychiatry. Indeed, in the United States, the VA has been responsible for the education and training of a large proportion of these subspecialists as well as specialists in other health professions. It is in keeping with the active role of the VA in the education and training of many health professionals throughout many years. For example, a large proportion of all physicians receive at least a portion of their postgraduate training at VA facilities. In the field of aging, the VA has created first-rate clinical as well as research centers throughout the country, and working with VA patients has allowed trainees to learn about late-life disorders not only in women who make up the majority of the elderly population in non-VA settings, but in men as well. Among the earliest programs were those initiated through the auspices of Paul Haber at VA national headquarters in Washington, D.C. And, one of the strengths of the VA programs has been the involvement of professionals from various disciplines working either in VA or academic facilities or both, often with financial contributions from university as well as VA resources.

A good example has been the collaborative UCLA/VA fellowship training program in geriatric psychiatry, one of the longest existing such programs in this country. In addition to geriatric psychiatrists, geriatricians and neurologists as well as geropsychologists and social workers formed an integral part of the program. Drs. Jeffrey Cummings (neurology), John Beck, David Solomon, Jim Davis (Medicine), Manny Straker, S.Y. Tsai (psychiatry), and Asenath LaRue (psychology), to name just a few, joined with me as members of the initial faculty. Dr. Gary Small, one of the program’s first graduates, succeeded me as head of the fellowship program, and, just recently, Dr. David Sultzer succeeded him.

In my opinion, the multidisciplinary composition of research and clinical teams has been one of the most important factors in helping to advance our understanding of health and disease in older persons. Geriatricians working together with geriatric psychiatrists, and John Morley has been an outstanding example of them, have brought to bear their diverse backgrounds as well as their shared knowledge to elucidate the complexities of aging processes as they affect mind/body interactions. Depression and heart disease, to cite just two examples, often present differently in middle-aged adults as compared with older adults, and in the older adult, may interact so that each alters the course and outcome of the other. Heightened awareness of such interactions, I believe, has been important in stimulating creative new approaches to preventing and treating age-associated diseases and disabilities. And, they offer the hope that “mens sana in corpore sano” will become an option regardless of chronological age. I agree with John Morley’s conclusion that understanding the factors that allow centenarians to age successfully will be among the major scientific successes in the next 50 years.

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REFERENCE

European Initiatives and Future Fields of Interest in Geriatric Medicine

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John Morley’s synthesis of geriatric medicine history from ancient Egypt to today with a prospect for tomorrow is a giant task even for a tireless and very involved true geriatrician (1). As always, this very useful summary for Journal of Gerontology readers will lead to contrasting appreciation from those who had the chance to be quoted and those who were forgotten. We think of interest, first, is to stress a few nongovernmental (WHO and NATO) and European initiatives that were not mentioned, and, secondly, to focus on what will be future fields of interest in geriatric medicine.

The nongovernmental (WHO and NATO) and European initiatives include the following. In the early 1990s, WHO (2) and then NATO recognized the future impact of a greying world by organizing world consensus conferences (Vienna in 1993, New York in 1995) devoted to the setting-up of different “global aging” research programs. Unfortunately, these initiatives did not lead to valuable scientific data, but had several major impacts such as: a) the appreciation that population aging was not limited to developed countries but that developing and emerging